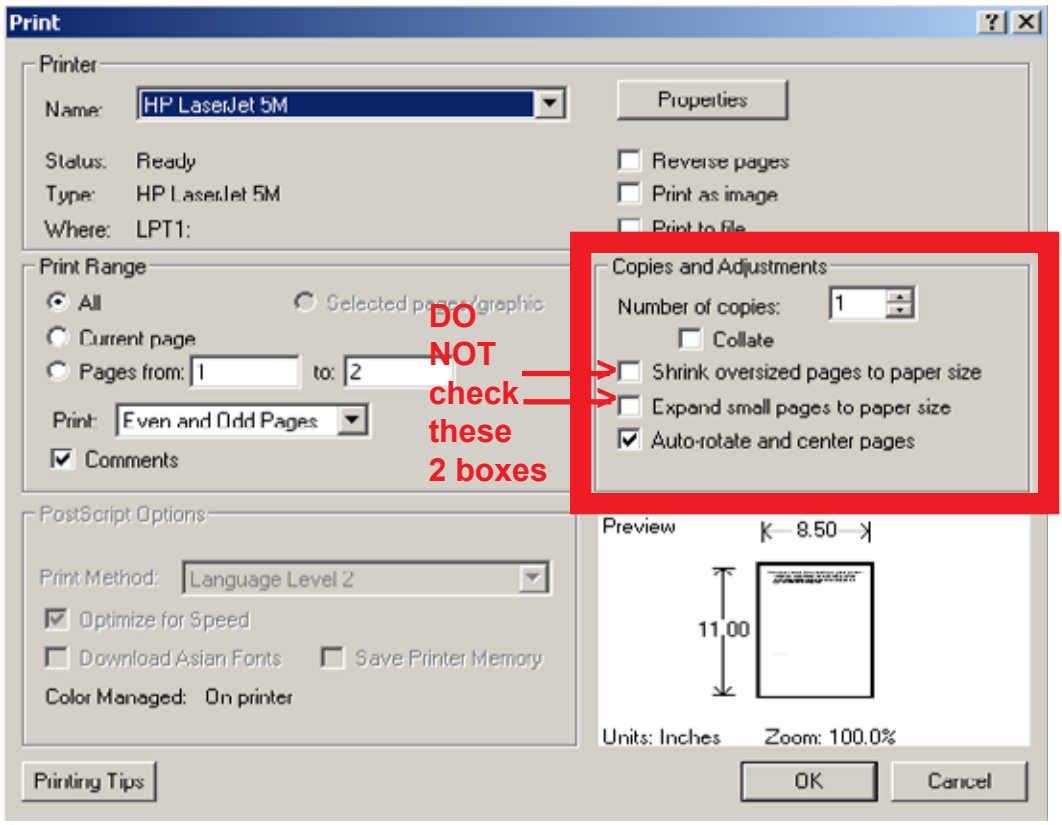
# Please read this before you print.

To print applications correctly, it is important to set up your print request as shown below. In the Adobe Acrobat Print dialog box, you must check the box “Auto-rotate and center pages.” Do **not** check the Shrink or Expand boxes.




DOH 600-033 (7/2006)

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Washington State Department of Health
Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099

# A. Contents:

## Licensed Practical Nurse Activation by Examination Packet



# B. Important Social Security Number Information:

* Federal and state laws require the Department of Health to collect your Social Security Number before your professional license can be issued. A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted. If you submit an application but do not provide your Social Security Number, you will not be issued a professional license and your application fee is not refundable.

* Federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 42 USC 666, RCW 26.23 and WAC 246-12-340.

# C. In order to process your request:

1. Complete the Deposit Slip below.
2. Cut Deposit Slip from this form on the dotted line below.
3. Send application with check and Deposit Slip to **PO Box 1099, Olympia, WA 98507-1099**.

**Cut along this line and return the form below with your completed application**

## Licensed Practical Nurse (Exam)

## DEPOSIT SLIP

NAME (Please Print) _____ DATE _____

Revenue Section
P.O. Box 1099
Olympia, Washington 98507-1099

**Please note amount enclosed, and return with your application.**

$ _____

☐ **Check**
☐ **Money Order**

DOH 669-226 (REV 7/2006)

1F 0257010000 00109

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Please Read This And Your NCLEX Candidate Bulletin

Washington State Department of Health
Washington State Nursing Commission
P.O. Box 1099
Olympia, WA 98507-1099

# Instructions for Completion of the Application for NCLEX-PN

## Washington State Application for NCLEX-PN:

1. Application completed in full.
2. Passport size (2"x2") picture of yourself, taken within the past year. **Applicant MUST sign the picture.**
3. Check or money order made payable to DOH (Dept. of Health) in the amount of $70. This fee is **NOT** refundable.
4. Verification of completion of the 7 hours HI/AIDS education requirement (graduates of Washington nursing programs do not need verification).
5. Mail the application, picture, HIV/AIDS document (if applicable) and $70 fee to this address:

   Department of Health
   Nursing Commission
   P.O. Box 1099
   Olympia, WA 98507-1099

## Certification Form:

1. Request your school of nursing send the completed **certification** form to this office **AFTER** you have completed your program. This form have the school seal and signature of the program coordinator or director.
2. If you have had a name change after submitting the application and prior to the school submitting the certification form, ensure all names are submitted by your school to this office.

## Transcripts:

Request the Registrar of your school of nursing to forward an official transcript, with the **degree you received and the date granted, posted.**

## Time Frames:

From the time you mail the "application for NCLEX-PN" with the fee, until we have you on the system is usually two weeks. Please do not call in that time period concerning your application. We may not be able to help you.

## NCLEX-PN Candidate Bulletin:

Please carefully read and follow the directions in your Candidate Bulletin. Do not throw this away until after you receive your results. The Candidate Bulletin will tell you how to complete and file the registration form with the testing company, and is full of other very important information.

**Note:** Results are mailed approximately **one (1) week after examination**. Please **do not** call before that time concerning your results, we will not be able to help you.

If you require further clarification, please refer to your NCLEX Candidate Bulletin.

### Failure/Retake:

You will be issued a license upon passing. Should you fail the exam, the Nursing Commission office will mail your results with instructions for retaking the exam. You have 4 opportunities in a two-year period of time to successfully complete the NCLEX-PN. There is a 91-day wait between exams.

Should you have questions concerning the exam and licensing, please call (360) 236-4706.

# HIV/AIDS Information

## AIDS Education Requirements for Health Related Professions

All health related professions under the disciplinary authority of the Uniform Disciplinary Act (RCW 18.130) are affected. This requirement went into effect January, 1989.

The topics that must be covered by this requirement are: ***etiology and epidemiology, testing and counseling, infectious control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality and psychosocial issues to include special population considerations.*** The course must be seven (7) hours or more in length.

If you completed your nursing program in 1989 or later and completed this requirement in the nursing courses, or a CE course, etc., after this time, you may complete the attestation portion of your application which specifies you have met this requirement. Keep documentation of completion for future reference. You may need to show proof to an employer.

If you feel you have not met this requirement, or you cannot document that you have, you can meet this requirement through a correspondence course or a community college. A partial listing of available offerings follows:

**Robert D. Anderson Publishing Company**
1-800-532-2332

**Washington State University**
Intercollegiate College of Nursing
1-800-281-2589

**University of Washington**
(206) 543-1047

**Impact Inc.**
(206) 284-3865

**Department of Health**
AIDS Information Hot Line
1-800-272-2437
Website: www.doh.wa.gov/cfh/hiv.htm Select “prevention”

**New York State Nurses Association**
(518) 782-9400
E-mail: info@nysna.org
Website: http://www.nysna.org

Washington State Department of Health

Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099

| FOR OFFICE USE ONLY | | |
|---|---|---|
| LICENSE DATE | CANDIDATE NUMBER | VALIDATION NUMBER |
| SCHOOL CODE | GRADUATE DATE | |

☐ AIDS ☐ Cert ☐ MBOS ☐ Verif (Foreign) ☐ Photo
☐ Scripts ☐ CGFNS ☐ TOEFL ☐ Active License) ☐ Other

LICENSE #

# Application For License By Examination Or Endorsement

☐ **Registered Nurse** ☐ Examination ☐ Endorsement

☐ **Licensed Practical Nurse** ☐ Examination ☐ Endorsement

**Please Type or Print Clearly**—Follow carefully all instructions in the general instructions provided. It is the responsibility of the applicant to submit or request to have submitted all required supporting documents. Failure to do so could result in a delay in processing your application. All applications must be accompanied by applicable fee which is non-refundable. Photo copied applications are not accepted. Make remittance payable to the Department of Health.

## 1. Demographic Information

| APPLICANT'S NAME LAST | FIRST | MIDDLE INITIAL |
|---|---|---|
| | | |

MAILING ADDRESS

| CITY | STATE | ZIP | COUNTY |
|---|---|---|---|
| | | | |

| TELEPHONE (ENTER THE NUMBER AT WHICH YOU CAN BE REACHED DURING **NORMAL BUSINESS HOURS**.) | RESIDENCE TELEPHONE | SOCIAL SECURITY NUMBER (**Required** for license under 42 USC 666 and Chapter 2.23 RCW) |
|---|---|---|
| ( ) | ( ) | — — |

| GENDER | BIRTHDATE (MO/DAY/YR) | PLACE OF BIRTH (CITY/STATE) |
|---|---|---|
| ☐ Male ☐ Female | | |

Have you ever been known under any other name(s)? ☐ Yes ☐ No

If yes, list

Attach Current Photograph Here. Indicate Date Taken and Sign in Ink Across Bottom of the Photo. **Required for examination only, not endorsement applicants.**
NOTE: Photograph **Must** Be:
1. Original, not a photocopy
2. No larger than 2" X 2"
3. Taken within one year of application
4. Close up, front view—not profile
5. Instant Polaroid Photographs **not** acceptable

## 2. Education

High school graduate? ☐ Yes ☐ No

If no, GED? ☐ Yes ☐ No

| INSTITUTION | NAME | LOCATION | DATE ENTERED | DATE COMPLETED | DIP/DEGREE GRANTED |
|---|---|---|---|---|---|
| COLLEGE OR UNIVERSITY | | | | | |
| COLLEGE OR UNIVERSITY | | | | | |
| COLLEGE OR UNIVERSITY | | | | | |
| COLLEGE OR UNIVERSITY | | | | | |

## 3. AIDS Education and Training Attestation

I certify I have completed the minimum of seven (7) hours of education in the prevention, transmission and treatment of AIDS, which included the topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychosocial issues to include special population considerations. I understand I must maintain records documenting said education for two (2) years and be prepared to submit those records to the Department if requested. I understand that should I provide any false information, my license may be denied, or if issued, suspended or revoked.

| APPLICANT'S INITIALS | DATE |
|---|---|
| | |

## 4. Personal Data Questions

| | YES | NO |
|---|---|---|
| 1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain. | ☐ | ☐ |

**"Medical Condition"** includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

1a. If you answered "yes" to question 1, please explain whether and how the limitations or impairments caused by your medical condition are reduced or eliminated because you receive ongoing treatment (with or without medications).

1b. If you answered "yes" to question 1, please explain whether and how the limitations and impairments caused by your medical condition are reduced or eliminated because of your field of practice, the setting or the manner in which you have chosen to practice.

(If you answered "yes" to question 1, the licensing authority (Board/Commission or Department as appropriate) will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition, the ongoing treatment, and the factors in "1b" so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure.)

| | | |
|---|---|---|
| 2. Do you currently use chemical substance(s) in any way which impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain. | ☐ | ☐ |

**"Currently"** means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

**"Chemical substances"** includes alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

| | | |
|---|---|---|
| 3. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or frotteurism? | ☐ | ☐ |
| 4. Are you currently engaged in the illegal use of controlled substances? | ☐ | ☐ |

**"Currently"** means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

**"Illegal use of controlled substances"** means the use of controlled substances obtained illegally (e.g., heroin, cocaine) as well as the use of legally obtained controlled substances, not taken in accordance with the directions of a licensed health care practitioner.

**Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The Department does criminal background checks on all applicants.**

| | | |
|---|---|---|
| 5. Have you ever been convicted, entered a plea of guilty, nolo contendere or a plea of similar effect, or had prosecution or sentence deferred or suspended, in connection with: | | |
| a. the use or distribution of controlled substances or legend drugs? | ☐ | ☐ |
| b. a charge of a sex offense? | ☐ | ☐ |
| c. any other crime, other than minor traffic infractions? (Including driving under the influence and reckless driving) | ☐ | ☐ |
| 6. Have you ever been found in any civil, administrative or criminal proceedings to have: | | |
| a. possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diverted controlled substances or legend drugs, violated any drug law, or prescribed controlled substances for yourself? | ☐ | ☐ |
| b. committed any act involving moral turpitude, dishonesty or corruption? | ☐ | ☐ |
| c. violated any state or federal law or rule regulating the practice of a health care professional? | ☐ | ☐ |
| 7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", explain and provide copies of all judgments, decisions, and agreements. | ☐ | ☐ |
| 8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority, or have you ever surrendered such credential to avoid or in connection with action by such authority? | ☐ | ☐ |
| 9. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence or malpractice in connection with the practice of a health care profession? | ☐ | ☐ |

## 5. Previous Licensure

List all states where any health care licenses are or were held. Specifically list licenses granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if license is current.

| STATE/JURISDICTION | PROFESSION | LICENSE TYPE | LICENSE | | METHOD OF LICENSURE |
|---|---|---|---|---|---|
| | | | YEAR ISSUED | NUMBER | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

## 6. Licensure In Other State(s) Or Country(ies)

List all states/countries you have held an RN or an LPN license in. List these licenses in the order they were issued to you (1st, 2nd, 3rd, etc.)

| STATE/COUNTRY | CHECK ONE | | CURRENT EXPIRATION DATE |
|---|---|---|---|
| | AS RN | AS LPN | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**State** or **country** in which originally licensed by examination. _____

Year license first issued _____ as an ☐ RN ☐ LPN

Have you taken the State Board Test Pool Examination (SBTPE) or NCLEX in the United States? ☐ Yes ☐ No

If yes, state _____ as an ☐ RN ☐ LPN

Have you ever applied for licensure in Washington prior to this application? ☐ Yes ☐ No

If yes, under the name of _____ as an ☐ RN ☐ LPN Approximate date _____

## 7. Applicant's Attestation

I, _____, certify that I am the person described and identified in
NAME OF APPLICANT

this application; that I have read RCW 18.130.170 and 180 of the Uniform Disciplinary Act; and that I have answered all questions truthfully and completely, and the documentation provided in support of my application is, to the best of my knowledge, accurate. I further understand that the Department of Health may require additional information from me prior to making a determination regarding my application, and may independently validate conviction records with official state or federal databases.

I hereby authorize all hospitals, institutions or organizations, my references, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Department any information files or records required by the Department in connection with processing this application.

I further affirm that I will keep the Department informed of any criminal charges and/or physical or mental conditions which jeopardize the quality of care rendered by me to the public.

_____ _____
SIGNATURE OF APPLICANT DATE

**Official Use Only**

**Washington State Records Center**

Washington State Department of Health
Health Professions Quality Assurance
Nursing Commission
PO Box 47864
Olympia, WA 98504-7864

# Certificate of Completion of LPN Program
## (to be completed AFTER program completion)

I certify that the individual listed below **HAS** completed all requirements for the degree/diploma for the approved Licensed Practical Nurse program as outlined in WAC 246-840-5675. I understand that my signature on this form will allow this individual to sit for the practical nurse licensure examination. **An official transcript with the degree/diploma posted will follow as soon as it is available.**

| | |
|---|---|
| LAST NAME OF GRADUATE | |
| FIRST NAME | MIDDLE NAME/INITIAL |
| DATE OF BIRTH (MO/DAY/YR) | SOCIAL SECURITY NUMBER |
| DATE OF PROGRAM COMPLETION (MO/DAY/YR) | |

_____
Signature of Authorized Person

_____
Title

School

_____
Name of School of Nursing

Seal

Dated this _____ day of _____ , 2 _____

**An Official Transcript is attached or will follow as soon as possible.**

Please send completed form to:

Washington Nursing Commission
PO Box 47864
Olympia, WA 98504-7864